Important Disclosure Information

Dental Preferred Provider Organization (PPO) and Participating Dental Network (PDN) Plans

Note: Specific plan documents supersede general disclosures contained within, as applicable.

State mandates do not apply to self-funded plans. If you are unsure if your plan is self-funded, please confer with your benefits administrator.

Covered Benefits

Your plan of benefits will be determined by your employer and underwritten or administered by Aetna Life Insurance Company (Aetna*), 151 Farmington Avenue, Hartford, CT 06156. The benefits and main points of the Service Agreement or Group Policy for persons covered under your employer's plan of benefits will be set forth in the Booklet-certificate or Booklet, which will be provided to you at a later date.

Covered services may include dental care provided by general dentists and specialist dentists. However, certain limitations may apply. For example, the dental plan excludes or limits coverage for some services, including, but not limited to, cosmetic and experimental procedures. The information that follows provides general information regarding Aetna dental PPO/PDN** plans. Members should consult their plan documents for a complete description of what dental services are covered and any applicable exclusions and limitations.

Note that the Exclusive Provider Plan (EPP), the PPO MAX /PDN MAX plan and the Aetna HealthFund®/Aetna DentalFund® products operate differently than the PPO/PDN plan. Check your plan documents for specifics about how these plans work. This disclosure information does not apply to these plans/products.

Cost Sharing

You are responsible for any copayments, coinsurance and deductibles for covered services. These obligations are paid directly to the provider or facility at the time the service is rendered. Copayment, coinsurance and deductible amounts are listed in your plan documents.

Emergency Care

If you need emergency dental care, you are covered 24 hours a day, 7 days a week, anywhere in the world. When emergency services are provided by a participating PPO/PDN dentist, your copayment/coinsurance amount will be based on a negotiated fee schedule.

Note that the Exclusive Provider Plan (EPP) has a different emergency care policy than the PPO/PDN plan. Check your plan documents for specifics about how the EPP emergency care policy works.

How Aetna Compensates Your Dentist and Other Providers

Participating PPO/PDN dentists are reimbursed on a fee-for-service basis. Any member coinsurance payments are based on the dentist's contracted fee schedule. Nonparticipating dental professionals providing covered services are reimbursed on a fee-for-service basis, subject to plan terms and conditions, as determined by Aetna.

You are encouraged to ask your dentists and other providers how they are compensated for their services.

Clinical Review

Aetna has developed a dental clinical review program to assist in determining what dental services are covered under the dental plan and the extent of such coverage. Some services may be subject to retrospective review. Only dental consultants who are licensed dentists make clinical determinations. Members and/or providers are notified of the reasons for a denial of coverage and of the applicable appeals process. For more information concerning Clinical Reviews or any other topic, please call the number on your ID card.

* Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

** In Texas, PPO is known as PDN.

www.aetna.com

We want you to know®

Aetna®

Grievances and Appeals

Our grievance process is designed to address your coverage issues, complaints and problems. If you have a coverage issue or other problem, call Member Services at the toll-free number on your ID card. If Member Services is unable to resolve your issue, complaint or problem to your satisfaction, you can request your concern be forwarded to the regional Grievance and Appeals Unit as follows:

- Northeast Territory – includes Mid-Atlantic and North-Eastern states (CT, DE, DC, IL, IN, KY, ME, MD, MA, MI, NH, NJ, NY, OH, PA, RI, VA, VT, WV, WI)

  Aetna Dental Grievance and Appeals Unit
  P.O. Box 14080
  Lexington, KY 40512-4080
- South Territory – (AL, AR, FL, GA, LA, MS, NC, OK, SC, TN, TX)

  Aetna Dental Grievance and Appeals Unit
  P.O. Box 14597
  Lexington, KY 40512-4597
- West Territory – (AK, AZ, CA, CO, HI, IA, ID, KS, MN, MO, MT, ND, NE, NV, NM, OR, SD, UT, WA, WY)

  Aetna Dental Grievance and Appeals Unit
  P.O. Box 10412
  Van Nuys, CA 91410

You can also contact Member Services at **www.aetna.com**. If you are dissatisfied with the outcome of your initial contact, you may file a written grievance with our Grievance and Appeals Unit at the applicable address listed above.

If you are not satisfied after filing a formal grievance, you may appeal the decision. Your appeal will be decided in accordance with the procedures applicable to your plan and applicable state laws. Refer to your plan documents for details regarding your plan's grievance procedures.

You can link to state insurance department websites through the National Association of Insurance Commissioners (NAIC) at **www.naic.org**.

Privacy Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to your physical or mental health or condition, the provision of health care to you, or payment for the provision of health care to you. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify you.

When necessary or appropriate for your care or treatment, the operation of our health plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating network providers are also required to give you access to your medical records within a reasonable amount of time after your request.

Some of the ways in which personal information is used include claims payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health claims analysis and reporting; health services research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health plans. To the extent permitted by law, we use and disclose personal information as provided above without your consent. However, we recognize that you may not want to receive unsolicited marketing materials unrelated to your health benefits. We do not disclose personal information for these marketing purposes unless you consent. We also have policies addressing circumstances in which you are unable to give consent.

To obtain a hard copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please write to:

Aetna Legal Support Services Department
151 Farmington Avenue, W121
Hartford, CT 06156

You can also visit **www.aetna.com** and link directly to the Notice of Privacy Practices by selecting the "Privacy Notices" link at the bottom of the page.

State Variations

Following are additional disclosures or variations to disclosures specific to certain states. You can also find some state-specific disclosures posted on our website at www.aetna.com.

Colorado

Colorado law requires carriers to make available a Colorado Health Benefit Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

Georgia

Members can call 1-877-238-6200 (toll free) to confirm that the dental provider in question is in the network and/or accepting new patients.

A summary of any agreement or contract between Aetna and any health care provider will be made available upon request by calling the Member Services telephone number on your ID card. The summary will not include financial agreements as to actual rates, reimbursements, charges, or fees negotiated by Aetna and the provider. The summary will include a category or type of compensation paid by Aetna to each class of provider under contract with Aetna.

Hawaii

Informed Consent:

Members have the right to be fully informed making any decision about any treatment, benefit, or nontreatment.

Your dental provider will:

- Discuss all treatment options, including the option of no treatment at all
- Ensure that persons with disabilities have an effective means of communication with the provider and other members of the managed care plan
- Discuss all risks, benefits, and consequences to treatment and non-treatment

Insurance Division Telephone Number:

You may contact the Hawaii Insurance Division and the Office of Consumer Complaints at: 1-808-586-2790.

Illinois

While every primary care dentist listed in the Dental Directory contracts with Aetna to provide primary care services, not every provider listed will be accepting new patients. Although we have identified those providers who were not accepting patients as known to us at the time the Dental Directory was created, the status of the dental practice may have changed. For the most current information regarding the status change of any dental practice, please contact either the selected dentist or Member Services at the number on your ID card. You may obtain additional information regarding the network, participating providers, or our grievance procedures through the DocFind® directory at **www.aetna.com** or by calling 1-877-238-6200.

Kansas

Kansas law permits you to have the following information upon request:

1. A complete description of the dental care services, items and other benefits to which the insured is entitled in the particular dental plan which is covering or being offered to such person
2. A description of any limitations, exceptions or exclusions to coverage in the dental benefit plan, including prior authorization policies or other provisions that restrict access to covered services or items by the insured
3. A listing of the plan's participating dental care providers, their business addresses and telephone numbers, their availability, and any limitation on an insured's choice of provider
4. Notification in advance of any changes in the dental benefit plan that either reduces the coverage or benefits or increases the cost, to such person
5. A description of the grievance and appeal procedures available under the dental benefit plan and an insured's rights regarding termination, disenrollment, nonrenewal or cancellation of coverage

Kentucky

Any dental care provider who meets our enrollment criteria and who is willing to meet the terms and conditions for participation has a right to become a participating provider in our network.

Appeals

1. As a member of Aetna, you have the right to file an appeal about service(s) you have received from your dental care provider or Aetna, when you are not satisfied with the outcome of the initial determination and the request is regarding a change in the decision for:
   - Certification of health care services
   - Claim payment
   - Plan interpretation
   - Benefit determination
   - Eligibility
2. You or your authorized representative may file an appeal within 180 days of an initial determination. You may contact Member Services at the number listed on your identification card.
3. A Customer Resolution Consultant will acknowledge the appeal within five (5) business days of receipt. A Customer Resolution Consultant may call you or your dental care provider for dental records and/or other pertinent information.
4. Our goal is to complete the appeal process within 30 days of receipt of your appeal. An appeal file is reviewed by an individual who was neither involved in any prior coverage determinations related to the appeal nor a subordinate of the person who rendered a prior coverage determination. A dentist or other appropriate clinical peer will review clinical appeals. A letter of resolution will be sent to you upon completion of the appeal. It is important to note that it is a covered member's right to submit new clinical information at any time during the appeal of an adverse determination or coverage denial to an insurer or provider.
5. If the appeal is for a decision not to certify urgent or ongoing services, it should be requested as an expedited appeal. An example of an expedited appeal is a case where a delay in decision-making might seriously jeopardize the life or health of the member or jeopardizes the member's ability to regain maximum function. An expedited appeal will be resolved within 72 hours. If you do not agree with the final determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.
6. If you are dissatisfied with the outcome of a clinical appeal and the amount of the treatment or service would cost the covered individual at least $100.00 if they had no insurance, you may request a review by an external review organization (ERO). The request must be made within 60 days of the final internal review. A request form will be included in your final determination letter. It can also be obtained by calling Member Services. A decision will be rendered by the ERO within 21 calendar days of your request. An expedited process is available to address clinical urgency. If you disagree with the decision regarding your right to an external review, you may file a complaint with the Kentucky Department of Insurance.
7. As a member, you may, at any time, contact your local state agency that regulates health care service plans for complaint and appeal issues, which Aetna has not resolved or has not resolved to your satisfaction. Requests may be submitted to:

   Kentucky Department of Insurance
   P.O. Box 517
   Frankfort, KY 40602-0517
8. You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your plan administrator, your local U.S. Department of Labor Office and your state insurance regulatory agency.

Maryland

For quality of care issues and life and health care insurance complaints you may contact:

Aetna Dental Grievance and Appeals Unit
P.O. Box 14080
Lexington, KY 40512-4080
Telephone: 1-877-238-6200

or Maryland Insurance Administration of Life and Health Insurance Complaints

200 Saint Paul Place, Suite 2700
Baltimore, MD 21202-2272
Telephone: 1-800-492-6116 (toll free); or
Telephone: 410-468-2244
Facsimile: 410-468-2243

For assistance in resolving a billing or payment dispute with the health plan or a health care provider you may contact:

Aetna Dental Grievance and Appeals Unit
P.O. Box 14080
Lexington, KY 40512-4080
Telephone: 1-877-238-6200 or

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
16th Floor 200 Saint Paul Place
Baltimore, MD 21202
Telephone: 410-528-1840
Facsimile: 410-576-7040

Nothing herein shall be construed to require the plan to pay counsel fees or any other fees or costs incurred by a member in pursuing a complaint or appeal.

Massachusetts

Members may request a copy of their Booklet-certificate by contacting their employer directly.

Michigan

Contact the Michigan Department of Consumer and Industry Services at 517-373-0220 to verify participating providers' licenses or to access information on formal complaints and disciplinary actions filed or taken against participating providers.

Transition of Care When a Provider Terminates From the Network

Aetna contracts are designed to provide transition of care for covered persons should the treating dental care provider contract terminate.

1. Participating dental care providers are contractually obligated for continued treatment of certain members after termination for any reason as outlined below:

   "Provider shall remain obligated at company's sole discretion to provide covered services to: (a) any member receiving active treatment from provider at the time of termination until the course of treatment is completed to company's satisfaction or the orderly transition of such member's care to another provider by the applicable affiliate of company; and (b) any member, upon request of such member or the applicable payor, until the anniversary date of such member's respective plan or for one (1) calendar year, whichever is less. The terms of this agreement shall apply to such services."

2. In cases of provider termination, in order to allow for the transition of members with minimal disruption to participating providers, Aetna may permit a member who has met certain requirements to continue an "Active Course of Treatment" for covered benefits with a non-participating provider for a transitional period of time without penalty subject to any out-of-pocket expenses outlined in the member's plan design.

Pennsylvania

This managed care plan may not cover all of your health care expenses. Read your contract carefully to determine which health care services are covered. To contact the plan if you are a member, call the number on your ID card; all others, call 1-877-238-6200.

Texas

Please refer to the plan design overview and summary of benefits contained in your pre-enrollment packet for a brief description of the services and benefits covered under your particular plan, as well as those services and benefits that are excluded. After enrollment, you can refer to your plan documents for a more complete description of your covered services and benefits and the exclusions under your plan. For information on whether a specific service is covered or excluded, please contact Member Services at the toll-free number on your ID card.

Virginia

Important Information Regarding Your Insurance

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

Aetna Life Insurance Company
P.O. Box 14080
Lexington, KY 40512-4597
Telephone: 1-877-238-6200

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Life and Health Division Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Telephone: 804-371-9691
Facsimile: 804-371-9944

The contact information, with the new name for the Center for Quality Health Care Services and Consumer Protection;

Office of Licensure and Certification
9600 Mayland Drive, Suite 4001
Richmond, VA 23233-1463
Toll Free: 1-800-955-1819
Richmond Metropolitan Area: 804-367-2106
Website: **www.vdh.virginia.gov/OLC/Complaints**

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Aetna Life Insurance Company is regulated as a Managed Care Health Insurance Plan (MCHIP) and as such, is subject to regulation by both the Virginia State Corporation Commission Bureau of Insurance and the Virginia Department of Health.

Washington State

The following materials are available: any documents referred to in the enrollment agreement; any applicable preauthorization procedures; dentist compensation arrangements and descriptions of and justification for provider compensation programs; circumstances under which the plan may retrospectively deny coverage previously authorized.*

If you need this material translated into another language, please call Member Services at 1-877-238-6200.
Si usted necesita este documento en otro idioma, por favor llame a Servicios al Miembro al 1-877-238-6200.

Note that the Exclusive Provider Plan (EPP), the PPO MAX/PDN MAX plan and the Aetna HealthFund®/Aetna DentalFund® products operate differently than the PPO/PDN plan. Check your plan documents for specifics about how these plans work. This disclosure information does not apply to these plans/products.

*This is a state mandate, which may apply to employer-funded plans.